



## Complete Summary

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### **GUIDELINE TITLE**

Diagnostic laparoscopy for pelvic pain and endometriosis. In: Diagnostic laparoscopy guidelines.

### **BIBLIOGRAPHIC SOURCE(S)**

Diagnostic laparoscopy for pelvic pain and endometriosis. In: Society of American Gastrointestinal and Endoscopic Surgeons (SAGES). Diagnostic laparoscopy guidelines. Los Angeles (CA): Society of American Gastrointestinal and Endoscopic Surgeons (SAGES); 2007 Nov. p. 58-61.

### **GUIDELINE STATUS**

This is the current release of the guideline.

This guideline updates a previous version: Society of American Gastrointestinal and Endoscopic Surgeons (SAGES). SAGES guidelines for diagnostic laparoscopy. Los Angeles (CA): Society of American Gastrointestinal and Endoscopic Surgeons (SAGES); 2002 Mar. 5 p.

## **COMPLETE SUMMARY CONTENT**

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## **SCOPE**

### **DISEASE/CONDITION(S)**

- Chronic pelvic pain
- Endometriosis

**Note:** Chronic pelvic pain is defined as pelvic pain lasting more than 6 months and is a complex disorder with multiple etiologies.

## **GUIDELINE CATEGORY**

Diagnosis  
Evaluation

## **CLINICAL SPECIALTY**

Obstetrics and Gynecology  
Surgery

## **INTENDED USERS**

Physicians

## **GUIDELINE OBJECTIVE(S)**

- To assist surgeons' decisions about the appropriate use of diagnostic laparoscopy in women with chronic pelvic pain and endometriosis
- To update the previous 2002 guidelines on this topic

## **TARGET POPULATION**

Women with chronic pelvic pain of unknown etiology after appropriate noninvasive workup

## **INTERVENTIONS AND PRACTICES CONSIDERED**

Diagnostic laparoscopy in patients with chronic pelvic pain

## **MAJOR OUTCOMES CONSIDERED**

- Conversion to open procedure rate
- Procedure-related/intraoperative complications
- Procedure-related morbidity
- Missed intraoperative complication rate
- Quality of life
- Mortality

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Hand-searches of Published Literature (Primary Sources)  
Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

A systematic literature search of MEDLINE for the period 1995-2005 was limited to English language articles. The search strategy is shown in Figure 1 in the original guideline document. Using the same strategy, the Cochrane database of

evidence-based reviews and the Database of Abstracts of Reviews of Effects (DARE) were searched.

Abstracts were reviewed by three committee members and into the following categories:

- Randomized studies, meta-analyses, and systematic reviews
- Prospective studies
- Retrospective studies
- Case reports
- Review articles

Randomized controlled trials, meta-analyses, and systematic reviews were selected for further review along with prospective and retrospective studies that included at least 50 patients; studies with smaller samples were reviewed when other available evidence was lacking. The most recent reviews were also included. All case reports, old reviews, and smaller studies were excluded.

The reviewers graded the level of evidence of each article and manually searched the bibliographies for additional articles that may have been missed by the search. Any additional relevant articles were included in the review and grading.

## **NUMBER OF SOURCE DOCUMENTS**

Not stated

## **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Weighting According to a Rating Scheme (Scheme Given)

## **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

### **Levels of Evidence**

Level I	Evidence from properly conducted randomized, controlled trials
Level II	Evidence from controlled trials without randomization Or Cohort of case-control studies Or Multiple time series, dramatic uncontrolled experiments
Level III	Descriptive case series, opinions of expert panels

## **METHODS USED TO ANALYZE THE EVIDENCE**

## Systematic Review

### DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

To maximize the efficiency of the review, articles were divided into three subject categories:

- Staging laparoscopy for cancer
- Diagnostic laparoscopy for acute conditions
- Diagnostic laparoscopy for chronic conditions

Reviewers graded the level of each article (see "Rating Scheme for the Strength of the Evidence.")

### METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

### DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The guidelines were developed under the auspices of the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) and revised by the SAGES Guidelines Committee.

The statements included in this guideline are the product of a systematic review of published work on the topic, and the recommendations are explicitly linked to the supporting evidence. The strengths and weaknesses of the available evidence are described and expert opinion sought where the evidence is lacking. This is an update of previous guidelines on this topic (last revision 2002) as new information has accumulated.

### RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

#### Scale Used for Recommendation Grading

Grade A	Based on high-level (level I or II), well-performed studies with uniform interpretation and conclusions by the expert panel
Grade B	Based on high-level, well-performed studies with varying interpretation and conclusions by the expert panel
Grade C	Based on lower-level evidence (level II or less) with inconsistent findings and/or varying interpretations or conclusions by the expert panel

### COST ANALYSIS

The literature was reviewed for published cost analyses. There are no available data of the cost-effectiveness of diagnostic laparoscopy for chronic pelvic pain.

### METHOD OF GUIDELINE VALIDATION

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The recommendations of each guideline undergo multidisciplinary review and are considered valid at the time of production based on the data available. This statement was reviewed by the Board of Governors of the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), November 2007.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

Definitions of the grades of the recommendations (**A, B, C**) and levels of evidence (**I, II, III**) are provided at the end of the "Major Recommendations" field.

#### **General Recommendations for Diagnostic Laparoscopy**

Diagnostic laparoscopy (DL) is a safe and well tolerated procedure that can be performed in an inpatient or outpatient setting under general or occasionally local anesthesia with intravenous sedation in carefully selected patients. DL should be performed by physicians trained in laparoscopic techniques who can recognize and treat common complications and can perform additional therapeutic procedures when indicated. During the procedure, the patient should be continuously monitored, and resuscitation capability must be immediately available. Laparoscopy must be performed using sterile technique along with meticulous disinfection of the laparoscopic equipment. Overnight observation may be appropriate in some outpatients.

#### **DL for Pelvic Pain and Endometriosis**

##### **Technique**

The procedure can be employed under general anesthesia or conscious sedation. The latter approach must be used with the technique of conscious pain mapping during which the patient can respond to intraperitoneal manipulations that may identify the source of pain. Smaller trocars and lower pneumoperitoneum pressures should be used with this technique to decrease the operative pain.

The patient is placed in the lithotomy position. The initial access site is usually peri-umbilical. Additional trocars can be placed in the left lower or right lower quadrant. A manipulator can be placed on the cervix and a rectal probe can be used if necessary for further retraction; these instruments are usually not used during conscious sedation.

During the procedure, identified adhesions are divided, and lesions suspected to be endometriosis should be biopsied and classified. In the absence of visible endometriosis lesions, random biopsies may demonstrate endometriosis in 30% of patients with typical symptoms. Free peritoneal fluid should be sampled and examined for the presence of endometriosis. Endometriosis lesions can then be fulgurated or removed.

## Indications

Chronic pelvic pain of unknown etiology after appropriate noninvasive workup.

## Recommendations

DL can be safely applied in the diagnosis of chronic pelvic pain (**Grade B**). The procedure may identify the etiology of chronic pelvic pain in a proportion of patients, and its diagnostic accuracy may be improved by the technique of conscious pain mapping (**Grade B**). Nevertheless, the existing evidence does not allow firm recommendations, and further research is needed to establish the value of DL for chronic pelvic pain (**Grade B**).

For details of the rationale for the procedure and its diagnostic accuracy, see the original guideline document.

## Definitions:

### Levels of Evidence

Level I	Evidence from properly conducted randomized, controlled trials
Level II	Evidence from controlled trials without randomization  Or  Cohort or case-control studies  Or  Multiple time series, dramatic uncontrolled experiments
Level III	Descriptive case series, opinions of expert panels

### Scale Used for Recommendation Grading

Grade A	Based on high-level (level I or II), well-performed studies with uniform interpretation and conclusions by the expert panel
Grade B	Based on high-level, well-performed studies with varying interpretation and conclusions by the expert panel
Grade C	Based on lower-level evidence (level II or less) with inconsistent findings and/or varying interpretations or conclusions by the expert panel

## CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

#### Pelvic Pain and Endometriosis

- Potential identification of the source of the chronic pelvic pain
- Possibility for immediate therapeutic intervention
- Potential improvement in the patient's quality of life

### POTENTIAL HARMS

Procedure- or anesthesia-related complications (see "Procedure-related Complications and Patient Outcomes" section in the original guideline document)

## CONTRAINDICATIONS

### CONTRAINDICATIONS

- Procedure intolerance
- Known dense pelvic adhesions that may make an accurate evaluation of pelvic pathology impossible or may impede safe abdominal access

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

Clinical practice guidelines are intended to indicate the best available approach to medical conditions as established by systematic review of available data and expert opinion. The approach suggested may not be the only acceptable approach given the complexity of the health care environment. These guidelines are intended to be flexible, as the surgeon must always choose the approach best suited to the patient and variables in existence at the time of the decision.

#### Limitations of the Available Literature

The quality of the available literature is limited, as almost all of the available studies are retrospective studies from single institutions. Furthermore, there is a paucity of data on long-term outcomes and little data on cost-effectiveness and quality of life. These shortcomings limit our ability to provide firm recommendations.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

### IMPLEMENTATION TOOLS

Foreign Language Translations  
Patient Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better  
Living with Illness

### IOM DOMAIN

Effectiveness  
Patient-centeredness  
Safety

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

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### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

1998 Apr (revised 2007 Nov)

### GUIDELINE DEVELOPER(S)

Society of American Gastrointestinal and Endoscopic Surgeons - Medical Specialty Society

**SOURCE(S) OF FUNDING**

Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)

**GUIDELINE COMMITTEE**

Guidelines Committee

**COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

Not stated

**FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Members of the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) disclose potential conflicts of interest and pertinent financial relationships prior to serving as faculty for SAGES-sponsored educational events, delivering presentations at scientific meetings, etc. Additionally, members of SAGES Committees disclose their potential conflicts of interest and pertinent financial relationships annually as a condition of committee membership.

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**GUIDELINE AVAILABILITY**

Electronic copies: Available from the [Society of American Gastrointestinal and Endoscopic Surgeons \(SAGES\) Web site](#).

Print copies: Available from the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), 11300 W. Olympic Blvd., Suite 600, Los Angeles, CA 90064; Web site: [www.sages.org](http://www.sages.org).

**AVAILABILITY OF COMPANION DOCUMENTS**

None available

**PATIENT RESOURCES**

The following is available:

- Patient information for diagnostic laparoscopy from SAGES. Available in English and Polish from the [Society of American Gastrointestinal and Endoscopic Surgeons \(SAGES\) Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## **NGC STATUS**

This summary was completed by ECRI on November 19, 1999. The information was verified by the guideline developer on February 15, 2000. This summary was updated by ECRI on March 22, 2004. The information was verified by the guideline developer on April 27, 2004. This summary was updated by ECRI Institute on March 2, 2009. The updated information was verified by the guideline developer on March 9, 2009.

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Date Modified: 4/13/2009

